Supreme Court, U.S.
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In the
Supreme Court of the United States

RAYMOND COCHRAN, Conservator of
Regina Elizabeth Hunter, a Protected Person,
Petitioner,

v.

TRANS-GENERAL LIFE INSURANCE COMPANY,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I.

WHERE AN INSURANCE COMPANY HAS AN INHERENT CONFLICT OF INTEREST WHICH PREVENTS IT FROM INTERPRETING THE LONG TERM DISABILITY PLAN SOLELY FOR THE BENEFIT OF ITS INSUREDS, SHOULD FEDERAL COURTS APPLY THE HIGHLY DEFERENTIAL "ARBITRARY AND CAPRICIOUS" STANDARD OF REVIEW IN ERISA CASES?

II.

WHERE THE CLAIMANT SUFFERED A CLOSED HEAD INJURY WHICH RENDERED HER INCAPABLE OF MAKING COMPETENT DECISIONS, SHOULD THE COURTS CONSIDER MEDICAL EVIDENCE NOT SUBMITTED TO THE INSURANCE COMPANY AT THE TIME HER APPEAL WAS DENIED?

LIST OF PARTIES

Petitioner

Raymond Cochran, Conservator of Regina Elizabeth Hunter is an individual with no corporate affiliations

Respondent

Trans-General Life Insurance Company is the respondent.

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JURISDICTION

This action was filed pursuant to ERISA, 29 U.S.C. § 1132(a)(1)(B), to enforce the terms of a fringe benefit plan. 29 U.S.C. § 1132(d)(i). The district court had jurisdiction pursuant to federal question (28 U.S.C. § 1331) jurisdiction. The judgment and opinion of the Court of Appeals for the Sixth Circuit was issued on April 13, 2001. This Petition for Certiorari was filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATEMENT

A. Facts.

Plaintiff Regina Hunter was born on September 9, 1955, and is presently 45 years old. In 1978, she obtained a Bachelor of Arts degree from the University of Michigan. In 1980, she received a Masters Degree in art education and community development, also from the University of Michigan.

In July, 1989, Hunter was hired by the Detroit East Community Mental Health Center as their Consultation,

Education and Prevention Director. While employed in this capacity, Hunter became a beneficiary of a long-term disability insurance policy purchased by Detroit East Community Mental Health Center from Trans-General Insurance.

On May 6, 1990, Hunter was rear ended in a chain reaction auto accident. Hunter was initially treated in an emergency room, where she was diagnosed with a shoulder strain and released. Not recognizing the severity of her injuries, Hunter attempted to return to work, but returned to the hospital two days later because of ringing in her ears, dizziness, and a bloody drainage out of her left eye. Hunter's family doctor referred her to a facility where she was given a neuropsychological evaluation on May 31, 1990. In that initial evaluation, the doctor noted increased pathological findings on clinical scales in the areas of motor functions, rhythm, writing, reading, and memory. The doctor concluded that Hunter's overall impairment rating was in the pathological range and diagnosed her as suffering from post concussion syndrome. Hunter began treatment for her closed head injuries and was referred to a board certified physical medicine and rehabilitation specialist, Dr. Mary Ann Guyon, M.D. Defendant Trans-General began paying long-term disability benefits in May, 1990.

Dr. Guyon initially evaluated Hunter on September 5, 1990. Her clinical impressions included a closed head injury secondary to cerebral concussion, post concussion syndrome, cognitive deficits, post traumatic stress disorder and sleep disorder, and myofascial strain of her neck and low back. Dr. Guyon indicated that Hunter's prognosis was guarded and that she was totally disabled from working at her regular job and her return to work is guarded because of the high level of her previous achievements.

A magnetic resonance image (MRI) of Hunter's brain showed a right parasellar mass. A MRI of her neck also indicated that she suffered from a herniated disc at the C7-T1 intervertebal level. Hunter's family doctor also referred her to a neurologist, who found that Hunter had an abnormal electroencephalagram (EEG) which revealed changes consistent with a closed head injury.

In February of 1991, Hunter began an inpatient cognitive rehabilitation program. A report by her occupational therapist in August of 1991 documents her significant problems in doing even volunteer work at the community agency where she had been previously employed.

On July 11, 1991, Hunter was discharged from the inpatient facility. Her primary therapist wrote a very positive report of her progress and stated that Hunter needed no supervision and was "functioning close to her status pre-injury". Dr. Guyon wrote a letter several months later, disagreeing with the rosy picture painted by the Haggerty Center discharge summary and expressing grave concerns over Hunter's continuing significant closed head injury deficits. In a letter dated October 20, 1991, Dr. Guyon concluded:

> She seems to me to still be the little girl that I previously saw prior to her going to the Haggerty Center. She is somewhat less confused but still has dizziness, still has a sleep disorder, still becomes somatically preoccupied when she is emotionally distressed, and does not really seem to have focused goal direction. Her personal life is extremely unstructured and she does not follow through with any of the memory and exercise techniques that would

> not only provide structure, allay anxiety, but help her on the job. I do not even know if she has had a job coach at the volunteer position. That is something to be considered.
>
> Suffice it to say, that I believe Regina Hunter still is not able to work more than twelve to sixteen hours per week at a noncompetitive job, is not able to always drive herself where she needs to be, is usually late, and shows too much emotional and cognitive immaturity to live alone in her own apartment without the medic alert.

In February, 1992, Hunter was approved for social security disability benefits for the period of May 6, 1990 through September 1, 1991. Hunter had been receiving long-term disability benefits from defendant Trans-General since May of 1990, and the award of Social Security benefits created an overpayment. At that point, payment of LTD benefits was withheld until $7,000.00 was repaid to defendant. After some negotiation, on June 1, 1992, defendant agreed to reduce the overpayment to $3,500.00, the amount that had already been withheld.

Four days after agreeing to resume Hunter's LTD payments, defendant cited plaintiff to a neurologist for an independent medical examination. On July 13, 1992, the doctor authored a report concluding that Hunter was not disabled and had no limitations whatsoever. Defendant notified Hunter that her benefits were terminated effective November 6, 1992 because of the IME report. On December 10, 1992, Hunter hand wrote a letter appealing this decision. Eight days later, Hunter's appeal was denied.

On February 16, 1993, defendant denied Plaintiff's appeal. No further appeal was filed by Hunter until she wrote a letter to defendant in 1997, requesting reinstatement of her benefits.

Meanwhile, Hunter's attempt to return to work was failing. She tried to increase her hours in her volunteer job and found that she couldn't do the work. Despite her continuing vocational rehabilitation assistance, she was still not able to become competitively employed.

Dr. Guyon's concerns about Hunter's impaired decision making were confirmed by Hunter's subsequent actions. When the agency where she was volunteering began to experience severe financial problems, Hunter loaned the agency over $40,000.00 from her auto negligence settlement, which was lost forever when the agency folded. In January of 1995, Hunter did manage to get her social security disability benefits reinstated.

Hunter began treating with a Dr. Shatz at the Rehab Pathways Group in October, 1997. Dr. Shatz noted Hunter's decision to loan $40,000.00 to the Green Glacier Agency and an incident involving a gun that resulted in criminal charges. Dr. Shatz concluded that Hunter was dangerous to herself and to others.

Neuropsychological testing in August, 1997, found continuing significant cognitive deficits. Hunter's need for closer supervision and a conservator to protect her from her own poor judgments was echoed by her new physiatrist, Dr. Owen Perlman, who took over the management of Hunter's care in June, 1997.

In March of 1997, Hunter wrote a letter to Trans General Insurance, requesting reinstatement of her benefits. This request was denied in a letter dated May 12, 1997.

B. Proceedings Below.

This ERISA action was filed in May, 1998, by her Conservator, Raymond Cochran, to appeal the termination of long-term disability benefits to Hunter. At the conclusion of discovery, defendant filed a Motion for Summary Judgment. In its Motion, defendant argued that it was entitled to summary judgment because the decision to terminate Hunter's long-term disability benefits was not arbitrary and capricious.

In the District Court's Memorandum Opinion and Order Granting Defendant's Motion for Summary Judgment, the district court found that the Plan required "satisfactory written proof" of disability and therefore established that Plan vested discretion in the defendant to award or terminate benefits. The court held that the "arbitrary and capricious" standard applied, and found that the defendant did not act arbitrarily and capriciously in terminating Hunter's LTD benefits. The district court also ruled that the court was limited to reviewing only those records which the defendant had available to it at the time the decision to terminate benefits was made.

Hunter filed a Motion for Reconsideration, which was denied on September 9, 1999. Hunter appealed, and on April 13, 2001, the Sixth Circuit Court of Appeals affirmed the district court's holding that the "arbitrary and capricious" standard applied. The Sixth Circuit also affirmed the lower court's decision that the decision to terminate Hunter's LTD benefits was not arbitrary and capricious.

REASONS FOR GRANTING THE WRIT

A.

WHERE AN INSURANCE COMPANY IS THE ADMINISTRATOR OF AN EMPLOYEE BENEFITS PLAN AND HAS AN INHERENT CONFLICT OF INTEREST WHICH PREVENTS IT FROM ADMINISTERING THE PLAN SOLELY FOR THE BENEFIT OF THE BENEFICIARIES, A LESS DEFERENTIAL STANDARD OF REVIEW IS APPROPRIATE.

U.S. employers provide long term disability insurance benefits to over 30 million employees. (See Table 2 in each of the following Bureau of Labor Statistics studies: "Employee Benefits in Small Private Establishments, 1996," Bulletin 2507, "Employee Benefits in Medium and Large Private Establishments, 1997" Bulletin 2517, and "Employee Benefits in State and Local Governments, 1998" Bulletin 2531.) Prior to the passage of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, dissatisfied claimants had the right to file a state law breach of contract action and have a jury decide whether the plan administrator's decision was in accordance with the plan or not.

However, since passage of ERISA, federal court review of benefits decisions has been governed by that statute and federal common law. Given ERISA's strong preemptive powers, federal courts are now the only recourse for claimants dissatisfied with plan administrator decisions. See *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987), *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58 (1987).

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, (1989), this Court reviewed ERISA's congressional history, intent, and statutory provisions and held that decisions of plan administrators would be reviewed under a *de novo* standard, **unless** the plan gave the administrator discretionary authority to construe the plan. *Ibid.*, 115. In rejecting *Firestone's* argument that interpretation of the terms of a plan is an inherently discretionary function, this Court stated at 489 U.S.112: "The trust law *de novo* standard of review is consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA."

After holding that the appropriate standard of review in that case was *de novo*, this Court concluded:

> Thus, for purposes of actions under § 1132(a)(12)(B), the *de novo* standard of review applied regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest. Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' Restatement (2nd) of Trusts § 187, Comment d (1959). (Emphasis added)

This Court's protection of plan recipients by recognizing the congressional intent of ERISA to protect beneficiaries was well founded. The legislative history of ERISA is replete with statements indicating that the intent of the law was to protect benefit plan participants and apply trust

principles to the fiduciary in charge of the employee retirement and benefit plans.

In ERISA's section 1001(b), 29 U.S.C. 1001(b), Congress provided specific mention of its intent to protect employees: ". . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefits plans in providing for appropriate remedies, sanctions, and ready access to the Federal courts."

The congressional intent to apply trust law standards to the administration of employee benefits plans is repeated throughout the legislative history of ERISA. On August 22, 1974, Senator Harrison Williams, Jr., Chairman of the Senate Committee on Labor and Pubic Welfare, indicated one of the areas of concern of the legislation was:

> Imposing strict fiduciary obligations upon those who exercise management or control over the assets or administration of an employee pension or welfare plan, as well as the provision of adequate reporting and disclosure requirements.
>
> Providing administrative and judicial remedies, available to both the government and participants, which will assure compliance with the foregoing substantive provisions. (Emphasis added) *Arnold & Porter Legislative History, Employee Retirement Security Act of 1974, HR Conference Report 93-1280,120 Congressional Record, S. 15737.*

The imposition of fiduciary obligations on plan administrators was repeated by Senator Williams further on

in the report under the heading, "Fiduciary Requirements" where he states:

> Accordingly, the legislation imposes strict fiduciary obligations on those who have discretion or responsibility respecting the management, handling, or disposition of pension or welfare plan assets. The objectives of these provisions are to make applicable the law of trusts; . . . and to provide effective remedies for breaches of trusts. *Ibid.* (Emphasis added)

Similarly, in the introductory statements by Senator Jacob Javits in introducing the original bill which became ERISA, Mr. Javits stated in the section under fiduciary responsibility:

> In the absence of a fiduciary responsibility section in the present act, courts applying trust law to employee benefit plans have allowed the same kind of deviations, even though the typical employee benefit plan, covering hundreds or even thousands of participants, is quite different from the testamentary trust, both in purpose and in nature. It is expected that courts will interpret the prudent man rule and other fiduciary standards bearing in mind the special nature and purposes of employee benefits plans intended to be effectuated by the Act. (Emphasis added) *Arnold & Porter Legislative History: ERISA Comm. Print 1973(2), (*274)*

Senator Javits continues on in this analysis stating:

> These salient principles place a two-fold duty on every fiduciary: to act in his relation to the plan's fund as a prudent man in a similar situation and under like conditions would act, and to act solely in the interest of the participants and beneficiaries of the plan. (Emphasis added) *Ibid.*

It is because ERISA "abounds with the language and terminology of trust law," and that the Act's fiduciary responsibility provisions codify trust law principles that the rule emerged that fiduciaries who had discretion should be subject to a lesser standard of review. *Firestone v Bruch, supra*, 489 U.S. 110-111.

The plan in the instant case involves a long-term disability (LTD) policy purchased by Hunter's former employer, Detroit East Community Mental Health Center. As an insurance company which simply administers the program for a premium, the insurance company has an inherent conflict of interest in administering the plan. See *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 387-389 (3rd Cir. 2000). To characterize the defendant insurance company as a fiduciary would violate the most fundamental duty of a fiduciary: the duty to act only in the interests of the beneficiary.

Section 170 of the Restatement (3rd) of Trusts provides: **"The trustee is under a duty to administer the trust solely in the interest of the beneficiaries."** Keeping in mind this important principle of trust law, obviously the insurance company's financial interest is in saving money by limiting or denying claims. This conflict of interest should be recognized in determining the applicable standard of review. The lower courts ignored this conflict of interest, holding that

it could not be considered without evidence that the conflict affected the plan administrator's decision. See Sixth Circuit Opinion, pp. 5-6.

While the Second and Seventh Circuits also require actual evidence of a conflict of interest in order to trigger greater scrutiny, *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998); *Whitney v. Empire Blue Cross & Blue Shield,* 106 F.3d 475 (2nd Cir. 1997), most other Circuits recognize the inherent conflict of interest in certain self-dealing arrangements. See cases collected in *Pinto, supra,* at 214 F.3d 384, including *Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1561 (11th Cir. 1990); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 86 (4th Cir. 1993); *Vega v. Nat'l Life Ins. Serv., Inc.*, 188 F.3d 287, 295-298 (5th Cir. 1999); *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263 (8th Cir. 1997); *Pitman v. Blue Cross & Blue Shield of Okla.*, 24 F.3d 118, 120-22 (10th Cir. 1994).

The Sixth Circuit's application of the arbitrary and capricious standard, without recognizing the inherent conflict of interest of insurance companies interpreting plan language, violates trust law principles discussed to by this Court in *Firestone v. Bruch, supra*, and makes a mockery of the legislative intent in Congress in enacting ERISA. An insurance company cannot be analogized to a trustee, who has a duty of loyalty to administer the trust solely in the interest of the beneficiary. Restatement (3rd) Trusts, § 170. An insurance company has an obvious financial interest in interpreting the trust in the interest of the insurance company, not the beneficiaries. Insurance companies paid premiums to administer long term disability insurance plans do not operate these plans for the sole benefit of plan participants. Therefore, the highly deferential arbitrary and capricious

standard in the instant case was inappropriate.

Since the *Firestone v. Bruch* decision, the Circuit Courts of Appeal have also grappled with the difficult issue of determining the appropriate standard of review where a conflict of interest has been found. However, without any guidance from this Court, significant conflicts in the standard of review have arisen among the circuits. This creates obvious problems of inconsistent results, depending on the location of the employee, and frustrates the goal of uniform application of federal law to ERISA cases.

The Third Circuit, in *Pinto v. Reliance Standard Life Ins. Co., supra,* at 214 F.3d 390-2, identified three different standards when reviewing courts find a conflict of interest in a ERISA plan administrator: (1) burden shifting, (2) *de novo*, and (3) sliding scale. In *Brown v. Blue Cross & Blue Shield of Ala., supra,* at 898 F.2d 1566-7, the Eleventh Circuit shifted the burden of proof to the fiduciary to prove that its interpretation was not tainted by self-interest. The Second Circuit, in *Sullivan v. LTV Aerospace & Defense Co.,* 82 F.3rd 1251, 1255-56, also applied a *de novo* standard of review after crediting evidence of a conflict of interest. Several other Circuits, including the Third Circuit in *Pinto, supra,* apply a "sliding scale" approach, decreasing the deference shown to the fiduciary depending on the seriousness of the conflict of interest: See cases collected in *Pinto, supra,* at 214 F.3d 390-392, including *Pinto, supra,* at 214 F.3d 393; *Doe v. Group Hospitalization & Med. Services, supra,* at 3 F.3d 87; *Vega v. National Life Ins. Services, Inc., supra,* at 188 F.3d 296; *Chambers v. Family Health Plan Corp.,* 100 F.3d 818 (10th Cir. 1996); and *Woo v. Deluxe Corp.,* 144 F.3d 1157, 1161-2 (8th Cir. 1998).

In this case, the lower courts should have taken into account the fact that the defendant Trans General Life Insurance Company is not the employer and is administering a plan in which the claimant's employer had simply paid a premium for the benefit. As such, the insurance company is not in a position where it is evaluating Hunter's LTD claim solely under a duty of loyalty to the plan participants. In this case, the insurance company disregarded substantial evidence from the treating medical providers and relied upon one independent medical examiner when it terminated Plaintiff's long-term disability benefits. Therefore, under any other standard of review other than the highly deferential "arbitrary and capricious" standard of review, Hunter would have been able to obtain meaningful court review. It would make a mockery of the congressional intent in enacting ERISA if one IME opinion can effectively overrule competent and substantial treating medical opinions.

B.

WHERE THE BENEFICIARY OF AN EMPLOYEE BENEFIT PLAN IS UNDER A DISABILITY WHICH PREVENTS HER FROM MARSHALLING EVIDENCE ON HER OWN BEHALF, AN EXCEPTION TO THE GENERAL RULE LIMITING CONSIDERATION OF ONLY EVIDENCE SUBMITTED TO THE INSURANCE COMPANY AT THE TIME OF THE ORIGINAL DECISION WOULD BE IN THE INTERESTS OF JUSTICE.

Hunter's traumatic brain injury left her unable to manage her affairs and her poor judgment eventually led to the appointment of a conservator to manage her assets. Under

these circumstances, the courts should have the power to consider other medical evidence which the impaired person did not manage to present to the plan administrator in support of her claim.

It is no accident that Regina Hunter is represented by a conservator, a person appointed under Michigan law to protect a person who is unable to handle his or her own affairs. See Michigan Compiled Laws 700.461. Although Ms. Hunter was not protected by a conservator at the time of the denial of benefits, it is clear that her condition was such that she was unable to protect herself nor marshal the necessary medical evidence to support her appeal of denial of benefits.

In an affidavit by her treating physical medicine doctor, Dr. Mary Ann Guyon stated: "In my opinion, as a result of her closed head injury, Ms. Hunter has been incapable of making competent decisions regarding her personal affairs, including the decision whether to appeal the denial of her long term disability benefits and what medical evidence to submit to the insurance company."

A review of the insurance company's records confirms plaintiff's inability to produce evidence to support her appeal of the denial of her long-term disability benefits. In its letter dated October 29, 1992, denying Hunter any further benefits after November 6, 1992, the only specific evidence cited in support of its decision cutting off benefits was Dr. Judge's letter of July 16, 1992. Dr. Judge found no evidence of any closed head injury, but did not perform any neuropsychological testing and did not review a prior positive brain MRI nor a prior positive EEG study. The only medical evidence submitted by Hunter after Defendant's decision to terminate benefits was a letter dated December 7, 1992 from

Hunter's treating physician, Dr. Guyon, to the auto insurance carrier, and does not specifically address the issues raised in the cutoff of her benefits. This letter appears to have been received by Group America on January 13, 1993. On February 16, 1993, Group America again confirmed its denial of benefits and notified Hunter of her right to seek further review. Ms. Hunter did not seek further review until 1997, at which time she wrote another letter indicating that she felt that she was still totally disabled.

At the time she again sought review in 1997, additional treating medical evidence was available which would have supported her claim for benefits and challenged the IME findings. However, Hunter failed to recognize that she should submit any additional evidence. Between her cutoff in 1992 and 1997, her treating physician, Dr. Guyon had become very concerned about her condition and her inability to perform even part-time volunteer work. As evidence of her lack of judgment, when the agency where she was volunteering began experiencing severe financial problems, Hunter loaned the agency over $40,000.00 from her auto negligence settlement. This money apparently was lost forever when the agency folded. Dr. Guyon met with Mr. Long, Hunter's rehabilitation consultant on May 13, 1997, and discussed Hunter's need to have a conservator to handle her affairs.

There was other evidence which indicated her inability to use common sense judgment. Neuropsychologic testing by Dr. Charles Seigerman in August, 1997 found continuing significant cognitive deficits and recommended a conservator for financial management. This concern was echoed by another physiatrist's opinion, Dr. Owen Perlman, who evaluated Hunter on 6-16-97 and noted significant cognitive deficits and recommended that she obtain a conservator to

manage her financial affairs. Dr. Perlman also noted continuing problems with her decision-making by noting that she had moved in with an elderly gentleman to assist him in living, and ended up living in an unheated attic space. As a result of these recommendations, Ms. Hunter entered a residential program for closed head injury persons in November of 1997.

Only the Fifth Circuit has allowed consideration of evidence other than that submitted to the plan administrator. *Wildbur v. Arco Chemical Co.*, 974 F.2d 631 (5th Cir. 1992) However, in that case, the Fifth Circuit allowed additional evidence to assist the court in determining whether the administrator abused their discretion. Counsel has been unable to find any ERISA case which has addressed the issue of the claimant's competency and the evidence considered.

Hunter respectfully submits that under the facts of this case, the courts should recognize Hunter's inability to adequately represent herself in her appeal of the termination of her benefits. When a person with significant cognitive deficits is unable to manage her own affairs and is unable to effectively marshal existing treating medical evidence on her behalf, the courts should create an exception to the general rule that evidence considered should be limited only to that information which the insurance company had available to it at the time of the initial denial of benefits. By the time Hunter sought further review in 1997, there was important additional medical evidence establishing her continuing disability. Given Hunter's disability, that additional evidence should be considered by the courts in determining whether Hunter was, in fact, totally disabled under the terms of the policy.

CONCLUSION

Regina Hunter's life was tragically altered when she suffered a traumatic brain injury which left her with significant cognitive deficits. If one IME report can negate the substantial treating medical opinions in her favor, federal court review of ERISA decisions is rendered meaningless. Such a result is inconsistent with the legislative intent of ERISA, and leaves disability insurance claimants without any meaningful opportunity to challenge adverse rulings.

The substantial conflicts within the circuits over the many issues unresolved by this Court's decision in *Firestone v. Bruch, supra*, are a powerful demonstration of the need for this Court's guidance on these important federal issues. It is clear that the significant conflicts in the circuits have led to very different results for identical insurance companies, depending on which circuit the claimant happens to reside. Given the fact that over 30 million Americans receive disability insurance coverage from their employers, these significant conflicts deserve resolution so that ERISA interpretation is uniform around the country.

The Petitioner urges this Court to grant certiorari and restore uniformity and fairness to ERISA cases.

Respectfully submitted,

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APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

[Filed April 13, 2001]

Nos. 99-2102/2447

RAYMOND COCHRAN, Conservator of Regina Elizabeth Hunter, a Protected Person, *Plaintiff-Appellant*,

v.

TRANS-GENERAL LIFE INSURANCE COMPANY, a Pennsylvania Corporation, *Defendant-Appellee*.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN

BEFORE: NORRIS, SILER and BRIGHT, Circuit Judges.*

*The Honorable Myron Bright, Circuit Judge of the United States Court of Appeals for the Eighth Circuit, sitting by designation.

ALAN E. NORRIS, Circuit Judge. Raymond Cochran, as conservator of Regina Hunter (Hunter), brought suit under § 1132(a)(1)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (ERISA), after the defendant, Trans-General Life Insurance Company (Trans-General), terminated Hunter's long-term disability benefits. The district court affirmed the decision of the plan administrator to terminate benefits, denied Hunter's motion for reconsideration and imposed sanctions on Hunter's counsel under 28 U.S.C. § 1927. Hunter now appeals on the grounds that the district court applied the wrong standard of review to the plan administrator's decision, erroneously found that Hunter suffered from a mental disability, and abused its discretion by ordering counsel to pay Trans-General's reasonable attorneys' fees and costs under 28 U.S.C. § 1927. For the reasons set out below we **AFFIRM** the decision of the district court in part and **REVERSE** in part.

I.

Beginning in July 1989, Hunter worked as the director of consultation, education and prevention at the Detroit East Community Mental Health Center (Health Center). As an employee of the Health Center, Hunter became the beneficiary of a long-term disability policy (Plan) purchased by her employer from Group America Insurance Company (later known as Trans-General).[1] The Plan was created and operated pursuant to ERISA. The relevant portions of the Plan provided that long-term disability benefits would be paid for

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[1]Trans-General changed its name to Highmark Life Insurance Company on April 1, 1999.

24 months, but that payment beyond this period would be conditioned upon the claimant's being disabled from all occupations. Further, long-term benefits for a disability caused, or contributed to, by a mental disorder, were only payable for 24 months.

On May 6, 1990, Hunter was involved in a four-car chain reaction collision. As a result of this accident Hunter suffered from a closed head injury, post-concussion syndrome and associated neuropsychological difficulties. Unable to return to her previous job, Hunter received disability benefits from Trans-General from November 7, 1990 to November 7, 1992. In January 1992, Trans-General informed Hunter that her eligibility to receive benefits past November 7, 1992, was contingent upon her being disabled from all occupations. Following a report from Hunter's primary care physician, which indicated that Hunter could perform light work, Trans-General requested an independent medical examination. A neurologist conducted the exam in July 1992, and reported that Hunter's "neurologic examination was normal" and that there was no need for restrictions or limitations to be placed on Hunter. Following this report, Trans-General informed Hunter that her benefits would be discontinued on November 6, 1992, as she had not shown that she was disabled from all occupations.

On December 10, 1992, Hunter replied to this letter by asking that Trans-General consider further information submitted by another one of her doctors. Trans-General considered the report and, on February 16, 1993, informed Hunter that it would not alter its decision to terminate benefits. After an interval of almost five years, Hunter re-applied for benefits in 1997. Trans-General considered

Hunter's letter an appeal from the denial of benefits in 1992, and rejected it as untimely.

Hunter then brought an action in the Michigan courts, alleging breach of contract and violation of § 1132(a)(1)(B) of ERISA. Following removal to federal court, Trans-General filed a motion for summary judgment; the district court, construing the motion as one for entry of judgment affirming the plan administrator's decision, granted it on July 30, 1999.[2] The district court concluded that the plan administrator's decision to deny continued benefits had been neither arbitrary nor capricious and, alternatively, that the plan administrator would also have been entitled to terminate Hunter's benefits because of the Plan's 24-month limit on benefits for disabilities caused by a mental disorder.

Following this decision, Hunter filed a motion for reconsideration, asserting that the district court had erred when it stated that she claimed to suffer from a mental disability and had improperly failed to consider outside evidence unavailable to the plan administrator. Trans-General filed a responsive motion seeking sanctions against Hunter under 28 U.S.C. § 1927. The district court rejected Hunter's arguments and imposed sanctions on the grounds that Hunter's filing of a motion for reconsideration contesting the district court's alternative finding that Hunter suffered from a mental disability amounted to a vexatious multiplication of the proceedings. Following submissions regarding the costs

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[2]The district court found, and neither party contests, that Hunter's state law contract claims were preempted by ERISA.

and fees incurred by Trans-General, the district court ordered Hunter's counsel to pay Trans-General $538.13 in costs and $3,192.25 in attorneys' fees.

II.

We review the district court's judgment de novo. *See Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 613 (6th Cir. 1998). In this case Hunter argues that when an insurance company both funds and administers benefits a structural conflict of interest exists that makes application of the arbitrary and capricious standard of review erroneous.

District courts generally review ERISA challenges to denials of benefits under a de novo standard. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). However, if the plan grants the plan administrator discretion to determine eligibility for benefits, courts review those determinations under the arbitrary or capricious standard of review. *See Bartling v. Fruehauf Corp.*, 29 F.3d 1062, 1071 (6th Cir. 1994). In this case, the parties agree that the plan administrator had discretion to determine Hunter's continued eligibility for benefits; the plan administrator's decision is therefore reviewed under the arbitrary and capricious standard. "The arbitrary or capricious standard is the least demanding form of judicial review of administrative action. When it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious." *Davis v. Kentucky Fin. Cos. Ret. Plan*, 887 F.2d 689, 693 (6th Cir. 1989) (quoting *Pokratz v. Jones Dairy Farm*, 771 F.2d 206, 209 (7th Cir. 1985)).

Contrary to Hunter's assertion, the existence of a conflict of interest shapes application of, but does not change, the arbitrary and capricious standard of review. This court has noted that:

> Because an insurance company pays out to beneficiaries from its own assets rather than from the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business, and the conflict of interest is substantial. The court in *Brown* held that the abuse of discretion or arbitrary and capricious standard still applies, but application of the standard should be shaped by the circumstances of the inherent conflict of interest.

Miller v. Metro. Life Ins. Co., 925 F.2d 979, 984 (6th Cir. 1991) (citing *Brown v. Blue Cross & Blue Shield of Alabama*, 898 F.2d 1556, 1561-63 (11th Cir. 1990)) (internal citations omitted); *see also Firestone*, 489 U.S. at 115 (1989) ("Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion.") (internal quotation and citations omitted).

However, mere allegations of the existence of a structural conflict of interest are not enough; there must be some evidence that the alleged conflict of interest affected the plan administrator's decision to deny benefits. *See Peruzzi v. Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998) ("Because our review of the record reveals no significant

evidence that SummaCare based its determination on the costs associated with Mrs. Peruzzi's treatment . . . we cannot conclude that SummaCare was motivated by self-interest in this instance"); *see also Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998) ("We presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict"); *Sullivan v. LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996) ("[A] reasonable interpretation of the Plan will stand unless the participants can show not only that a potential conflict of interest exists, . . . but that the conflict affected the reasonableness of the Committee's decision") (internal quotation and citations omitted).

Here, the district court properly found that while the presence of a conflict of interest is a factor to be considered when reviewing a plan administrator's decisions, some evidence must be produced indicating how the alleged conflict affected the administrator's denial of the claimant's benefits. Hunter points to no evidence indicating that the plan administrator's decision to deny her continued benefits was influenced by the alleged structural conflict of interest. In the absence of such evidence, the district court correctly concluded that the decision of the plan administrator to deny Hunter continued benefits was a reasonable one based on the evidence before the administrator. We therefore affirm the district court's decision finding that Trans-General's decision to terminate Hunter's benefits was neither arbitrary nor capricious.

III.

This court reviews a district court's decision to impose sanctions under 28 U.S.C. § 1927 for an abuse of discretion. *See Ridder v. City of Springfield*, 109 F.3d 288, 298 (6th Cir. 1997). Section 1927 provides that:

> Any attorney or other person admitted to conduct cases in any court of the United States or any Territory thereof who so multiplies the proceedings in any case unreasonably and vexatiously may be required by the court to satisfy personally the excess costs, expenses, and attorneys' fees reasonably incurred because of such conduct.

In considering whether or not to impose sanctions, this court has cautioned that

> simple inadvertence or negligence that frustrates the trial judge will not support a sanction under section 1927. There must be some conduct on the part of the subject attorney that trial judges, applying the collective wisdom of their experience on the bench, could agree falls short of the obligations owed by a member of the bar to the court and which, as a result, causes additional expense to the opposing party.

In Re Ruben, 825 F.2d 977, 984 (6th Cir. 1987). In this case, we believe that the district court abused its discretion when it imposed sanctions upon Hunter's counsel.

The district court's decision to impose sanctions under 28 U.S.C. § 1927 centered on Hunter's motion for reconsideration in which Hunter contested the district court's alternative finding that she was not entitled to benefits because she was suffering from a mental disability. However, Trans-General had not raised the question of Hunter's alleged mental disability in its letter denying continued benefits, and the issue formed no part of the administrative record. A district court's review of a plan administrator's decision is limited to the evidence before the plan administrator at the time of the denial of benefits. *See Miller*, 925 F.2d at 986 ("when reviewing a denial of benefits under ERISA, a court may consider only the evidence available to the administrator at the time the final decision was made"). The district court thus should not have reached the question of whether Hunter suffered from a mental disability, and Hunter's decision to contest the court's decision to do so was not inappropriate or frivolous.

IV.

The decision of the district court, that Trans-General's decision to deny Hunter continued benefits was neither arbitrary nor capricious is **AFFIRMED**, while its decision to impose sanctions under 28 U.S.C. § 1927 is **REVERSED**.

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

[Filed September 9, 1999]
CIVIL CASE NO. 98-40191

RAYMOND COCHRAN, as conservator of Regina Elizabeth Hunter,
Plaintiff,

v.

TRANS-GENERAL LIFE INSURANCE COMPANY,
Defendant.

Honorable Paul V. Gadola, U.S. District Judge

OPINION AND ORDER DENYING PLAINTIFF'S MOTION FOR RECONSIDERATION

Presently before the Court is a motion for reconsideration filed on August 6, 1999 by plaintiff Raymond Cochran, as conservator of Regina Elizabeth Hunter. Plaintiff seeks reconsideration of this Court's July 30, 1999 memorandum opinion and order granting defendant Trans-General Life Insurance Company's motion for summary judgment. *See* Cochran v. Trans-General Life Ins. Co., 1999

WL 623325, -- F. Supp.2d -- (E.D.Mich. July 30, 1999). In the previous opinion, the Court construed defendant's motion as one seeking affirmance of the plan administrator's decision to deny plaintiff's claim for long-term disability benefits. The Court concluded that the plan administrator's decision to deny plaintiff's continued long-term disability benefits was not "arbitrary and capricious." On August 30, 1999, defendant submitted a response in opposition to plaintiff's motion for reconsideration pursuant to this Court's August 13, 1999 order allowing the same.

For the reasons set forth herein, plaintiff's motion for reconsideration of this Court's July 30, 1999 memorandum opinion and order granting defendant Trans-General Life Insurance Company's motion for summary judgment will be denied.[1]

I. LEGAL STANDARD

Pursuant to Local Rule 7.1(g) (3) (E.D. Mich. 1998), the Court will not grant a motion for reconsideration unless "[t]he movant . . . not only demonstrate[s] a palpable defect by which the court and the parties have been misled but also show[s] that correcting the defect will result in a different disposition of the case." *Id.* A motion for reconsideration which merely presents "the same issues ruled upon by the court, either expressly or by reasonable implication," shall be denied. *Id.*

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[1]The instant motion will be decided on the briefs submitted and without the necessity for oral argument pursuant to L.R. 7.1(e) (2) (E D.Mich. 1998).

Plaintiff incorrectly brings the instant motion pursuant to Rule 52(b) of the Federal Rules of Civil Procedure.[2] That Rule concerns findings by the court and judgment on partial findings after trial, i.e., "[i]n all actions tried upon the facts without a jury or with an advisory jury . . . ." Fed. R. Civ. Proc. 52(a). Since there has been no trial in the above-entitled case, but instead disposition of the case on the pleadings, plaintiff more properly should have filed a motion to alter or amend judgment pursuant to Federal Rule of Civil Procedure 59(e). "A motion to alter or amend judgment pursuant to Rule 59(e) may properly be analyzed as a motion for reconsideration pursuant to Local Rule 7.1 (E.D. Mich. 1998)." Hence v. Smith, 49 F. Supp.2d 547, 550 (E.D. Mich. 1999) (Gadola, J.). Accordingly, the Court will construe the instant motion as a motion for reconsideration under Local Rule 7.1, and not under Federal Rule of Civil

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[2]Federal Rule of Civil Procedure 59(b) provides, in full, that

> [o]n a party's motion filed no later than 10 days after entry of judgment, the court may amend its findings--or make additional findings--and may amend the judgment accordingly. The motion may accompany a motion for a new trial under Rule 59. When findings of fact are made in actions tried without a jury, the sufficiency of the evidence supporting the findings may be later questioned whether or not in the district court the party raising the question objected to the findings, moved to amend them, or moved for partial findings.

Procedure 52.

III. ANALYSIS

Plaintiff maintains that this Court erred in asserting that plaintiff claims a "mental disability." According to plaintiff, she has never asserted the basis of her disability as being a "mental" disability. Paradoxically, however, plaintiff concedes that "counsel [for plaintiff] pled the disability of insanity in the Complaint to avoid potential statute of limitation problems . . . ." Plaintiff's brief in support of motion for reconsideration, p. 2. Plaintiff further explains the allegation of insanity with the following rationale: "[i]n order to avoid any argument that Plaintiff was tardy in her litigation . . . over five years after the insurance company's decision, Plaintiff alleged in her Complaint in paragraph 10 that she was under a disability which would toll the statute pursuant to [M.C.L. § 600.5851]." *Id.* Plaintiff also argues that this Court erred in failing to consider outside evidence not available to the plan administrator at the time of the decision to deny benefits.

In response, defendant argues that plaintiff raises no new facts, evidence, nor case law which this Court has not already considered in the previous opinion. According to defendant, "[t]he heart of Plaintiff's instant motion is her claim that 'the Court mistakenly assumed Plaintiff was claiming a mental disability' . . . ." Defendant's brief in opposition, p. 3. Plaintiff maintains that the Court did not "mistakenly assume" that plaintiff claimed a mental disability, because she did in fact claim such a disability. *See* Complaint ¶ 10.

In addition, defendant points out that even assuming *arguendo* plaintiff was not limited by the two-year mental disorder limitation contained in the plan, the Court also affirmed the plan administrator's decision based upon the alternative ground that plaintiff had failed to satisfy the plan's definition of disabled. As this Court recognized, "[a]fter the expiration of 24 months . . . the Plan explicitly provides that benefits will be paid out only upon disability from 'all occupations.'" Cochran, 1999 WL 623325, *1. With respect to plaintiff's continued reference to information not contained within plaintiff's claim file, defendant maintains that such information is not new evidence, but evidence which was rejected by this Court as being outside of its purview. This Court expressly stated that "it [was] bound to consider only the evidence that was before the administrator at the time the final decision was made." *Id.*, *6.

The Court finds plaintiff's arguments in support of reconsideration wholly unavailing.The first issue concerns whether or not plaintiff suffers from a "mental" versus a "physical" disability. On May 6, 1990, plaintiff was involved in a chain reaction auto accident which resulted in "traumatic brain injury," in the words of plaintiff's counsel. However, as noted in the previous opinion, plaintiff's counsel also unequivocally stated in the complaint that "'[s]ince the motor vehicle accident in 1990, [p]laintiff has been under the disability of insanity as defined in [M.C.L. §] 600.5851.'" *See* Cochran, 1999 WL 623325, *9 (quoting Complaint ¶ 10). Moreover, plaintiff's claim of a "mental disorder" was further underscored by her reliance on M.C.L. § 600.5851 in her responsive brief. *See id.*, *10. In light of the above, it is disingenuous for counsel to now argue that plaintiff does not suffer from any mental disability.

Even assuming *arguendo* that plaintiff did not suffer from a mental disorder, contrary to plaintiff's allegation in the Complaint, this Court also found that the plan administrator was not arbitrary and capricious in denying plaintiff's long-term disability benefits based on her inability to satisfy the plan's definition of "disabled." Pursuant to the plan, after expiration of 24 months, benefits are to be paid out only upon disability from "all occupations." *See* Cochran, 1999 WL 623325, *1. This issue was previously ruled upon by the Court when it concluded that "defendant's determination that plaintiff was not disabled from all occupations cannot be said to have been arbitrary and capricious." *Id.*, *9.

Plaintiff's final argument that the Court erred in failing to consider outside evidence is similarly flawed. As the Court commented in the previous opinion, "[i]n reviewing the decision of the plan administrator, a court will look only to the evidence that was before the administrator at the time the final decision was made." Cochran, 1999 WL 623325, *6 (citing Holsey MD v. UNUM Life Ins. Co., 944 F.Supp. 573, 576-577 (E.D. Mich. 1996) (Gadola, J.) and Perry v. Simplicity Eng'g, 900 F.2d 963 (6th Cir. 1990)). Plaintiff cited (and now cites) absolutely no case law or other legal authority for the proposition that this Court may consider evidence outside the closed record.

Plaintiff has not "demonstrate[d] a palpable defect by which the court and the parties have been misled." L.R. 7.1(g)(3). Nor has plaintiff shown that "a different disposition of the case must result from a correction thereof." *Id.* Instead, plaintiff has merely presented "the same issues ruled upon by the court, either expressly or by reasonable implication." *Id.* Accordingly, plaintiff's motion for reconsideration of this

Court's July 30, 1999 memorandum opinion and order granting defendant Trans-General Life Insurance Company's motion for summary judgment will be denied.

As a final point, the Court notes that defendant has requested sanctions against plaintiff for excessive costs pursuant to 28 U.S.C. § 1927. That Section provides that "[a]ny attorney or other person admitted to conduct cases in any court of the United States . . . who so multiplies the proceedings in any case unreasonably and vexatiously may be required by the court to satisfy personally the excess costs, expenses, and attorneys' fees reasonably incurred because of such conduct." 28 U.S.C. § 1927. As this Court held on a previous occasion,

> "[a]pplication of § 1927 is warranted" when an attorney has engaged in some sort of conduct, that from an objective standpoint, "falls short of the obligations owed by a member of the bar to the court, and which as a result causes additional expense to the opposing party." Holmes v. City of Massillon, Ohio, 78 F.3d 1041, 1049 (6th Cir.1996) (citation omitted), *cert. denied*, Fabianich v. Holmes, -- U.S. --, 117 S.Ct. 312, 136 L.Ed.2d 228 (1996). The attorney's conduct must amount to more than simple inadvertence or negligence. *Id.* (citing Orlett v. Cincinnati Microwave, Inc., 954 F.2d 414, 419 (6th Cir. 1992)). The liability created under § 1927 is only for excessive costs due to persistent prosecution of a meritless claim. Browning v. Kramer, 931

> F.2d 340, 344 (5th Cir. 1991). Indeed, punishment under the statute is sparingly applied and the court should not shift the entire burden of an action's defense under 28 U.S.C. § 1927 unless the entire course of proceedings was unwarranted. F.D.I.C. v. Calhoun, 34 F.3d 1291, 1296 (5th Cir.1994) (citation omitted).

Pierzynowski v. Police Dept. City of Detroit, 947 F. Supp. 1147, 1151 (E.D. Mich. 1996) (Gadola, J.).

This Court finds that plaintiff's counsel is liable for attorney's fees and costs incurred by defendant in responding to the instant motion for reconsideration. The conduct of plaintiff's counsel clearly amounted to a vexatious multiplication of the proceedings. As discussed, *supra,* plaintiff's counsel has argued, quite paradoxically, that his client is not "mentally disabled," at the same time conceding that in the complaint it was alleged that plaintiff suffers from "insanity." Counsel for plaintiff boldly admits in the brief that the allegation of "insanity" was merely "to avoid potential statute of limitation problems. . . ." Defendant is thus entitled to its reasonable attorney's fees and costs incurred in responding to the instant frivolous motion pursuant to 28 U.S.C. § 1927.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that plaintiff's motion for reconsideration filed August 6, 1999 is **DENIED;**

IT IS FURTHER ORDERED that counsel for plaintiff is liable for the reasonable attorney's fees and costs incurred by defendant in responding to the instant frivolous motion for reconsideration pursuant to 28 U.S.C. § 1927;

IT IS FURTHER ORDERED that defendant file within 10 days an affidavit of reasonable attorney's fees and costs incurred by defendant in responding to the instant motion; following the filing of defendant's affidavit, this Court will issue a further order imposing reasonable attorney's fees and costs on plaintiff's counsel pursuant to 28 U.S.C. §1927.

SO ORDERED.

Dated: 9/7/99

/s/_____
HON. PAUL V. GADOLA
UNITED STATES DISTRICT JUDGE

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

[Filed July 30, 1999]
CIVIL CASE NO. 98-40191

RAYMOND COCHRAN,[1] as conservator of Regina Elizabeth Hunter,
Plaintiff,

v.

TRANS-GENERAL LIFE INSURANCE COMPANY,
Defendant.

Honorable Paul V. Gadola, U.S. District Judge

MEMORANDUM OPINION AND ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

[1]The complaint as originally filed listed the conservator as "Willie Mae Hunter." However, in a stipulated order entered January 22, 1999, this Court allowed the case caption to be amended to reflect Regina Elizabeth Hunter's new conservator, "Raymond Cochran."

Presently before the Court is a motion for summary judgment filed May 28, 1999 by defendant Trans-General Life Insurance Company (hereinafter "Trans-General"). The above-entitled action concerns a claim brought by plaintiff Willie Mae Hunter, as conservator of Regina Elizabeth Hunter, for long-term disability benefits under a disability policy issued by Ms. Hunter's former employer, Detroit East, Inc. There is no dispute that the policy at issue is a "qualified plan" pursuant to the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq.* On June 21, 1999, plaintiff responded to defendant's motion. Defendant submitted a reply brief on July 1, 1999.

For the reasons set forth below, the Court will grant defendant Trans-General's motion for summary judgment, construed as a motion for entry of judgment seeking affirmance of the plan administrator's decision to deny plaintiff's claim for long-term disability benefits.[2]

I. FACTUAL BACKGROUND

In July 1989, plaintiff Regina Elizabeth Hunter was hired by the Detroit East Community Mental Health Center as the director of consultation, education, and prevention. In this capacity, plaintiff became the beneficiary of a long-term disability policy (hereinafter "the Plan") purchased by her employer from Group America Insurance Company (now

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[2]Defendant's motion for summary judgment will be decided on the briefs submitted by the respective parties and without the necessity for oral argument pursuant to L.R. 7.1(e)(2)(E.D. Mich. 1998).

known as Trans-General Life Insurance Company), defendant herein. *See* Plan attached as Exh. B(1) to defendant's brief in support of motion for summary judgment.

The Plan contains the following language regarding scope of coverage:

> [u]ntil LTD DISABILITY BENEFITS have been paid for 24 months, you are only required to be DISABLED from your own occupation. You are DISABLED from your own occupation if, as a result of SICKNESS, ACCIDENTAL BODILY INJURY or PREGNANCY, you are EITHER:
>
> > b. Unable to perform with reasonable continuity the material duties of your own occupation; OR
> >
> > c. Unable to earn more than 80% of your INDEXED PREDISABILITY EARNINGS while working in your own occupation.

See id., pp. 4-5 (emphasis added). After expiration of 24 months, however, the Plan explicitly provides that benefits will be paid out only upon disability from "all occupations." As the Plan provides,

> [a]fter LTD BENEFITS have been paid for 24 months, you must be DISABLED from all occupations.

> You are DISABLED from you all occupations if, as a result of SICKNESS, ACCIDENTAL BODILY INJURY or PREGNANCY, you are EITHER:
>
> > a. Unable to perform with reasonable continuity the material duties of any gainfu! occupation for which you are reasonably fitted by education, training, and experiences or
> >
> > b. Unable to earn more than 80% of your INDEXED PREDISABILITY EARNINGS while working in your own or any other occupation.

Id.. p.5 (emphasis added). The Plan also contains a separate provision relating to payment of long-term disability benefits in cases involving a disability caused or contributed to by a mental disorder:

> MENTAL DISORDER: Payment of LTD BENEFITS is limited to 24 months for reach period of disability caused or contributed to by a MENTAL DISORDER. . .MENTAL DISORDER means a mental, emotional, or behavioral disorder.

Id., p. 7 (emphasis added).

On May 6, 1990, plaintiff was involved in a chain reaction auto accident. As a result of the accident, plaintiff complained of dizziness, neck and back pain. Plaintiff was

initially treated at Heritage Hospital, where she was diagnosed with a shoulder strain and released. Upon attempting to return to work a few days thereafter, plaintiff reported experiencing ringing in her ears, dizziness, and a bloody drainage out of her left eye.

On May 11, 1990, plaintiff saw her family physician, Dr. John Loomis, who referred her to the Genesis Group for neuropsychological testing. On May 31, 1990, Dr. Richard Weiss of the Genesis Group performed a neuropsychological evaluation of plaintiff. *See* Exh. B to plaintiff's brief in response to defendant's motion. Dr. Weiss' evaluation revealed that plaintiff's "current performance levels fall significantly below performance levels attained prior to her accident." *Id.*, p. 11. Dr. Weiss diagnosed plaintiff as suffering from post-concussion syndrome, an adjustment reaction with emotional features. Plaintiff was subsequently referred to a board certified physical medicine rehabilitation specialist, Dr. Mary Ann Guyon of Wyandotte Hospital.

On September 5, 1990, Dr. Guyon evaluated plaintiff, finding a closed head injury secondary to cerebral concussion, post-concussion syndrome, cognitive deficits, post-traumatic stress, sleep disorder, and myofascial strain of her neck and low back. *See* Exh. C to plaintiff's brief in response to defendant's motion. An MRI showed a right parasellar mass in plaintiff's brain, as well as a herniated disc. Dr. Guyon indicated that plaintiff was disabled from working at her regular job.

In February 1991, plaintiff began treatment at the Haggerty Center in their full day patient program for cognitive rehabilitation. *See* Exh. C to plaintiff's brief in

response to defendant's motion. As part of her rehabilitation, plaintiff began volunteering at Green Glacier Community Center, in Ann Arbor, Michigan. A report from her occupational therapist in August 1991 indicated that plaintiff was having difficulty in working at the community agency, including difficulty in organizational issues, fatigue, and inability to follow-up. *See* Exh. D to plaintiff's brief in response to defendant's motion.

In June 1991, plaintiff was discharged from the Haggerty Center. The discharge report, dated June 9, 1991, concluded that plaintiff's "need for supervision is no longer needed." *See* Discharge Summary, p. 9, attached as Exh. D. to plaintiff's brief in response to defendant's motion. The discharge report also contained the following assessment:

> Ms. Hunter is presently functioning at a level close to her status prior to her injury. The major difference is that she is not yet competitively employed. However she anticipates return to work soon. She is investigating options and is hopeful of doing consulting. Ms. Hunter continues to fatigue more easily, but is aware of when to refrain from pushing herself too far. Thus far, she has been monitoring herself effectively.

Id.

In February 1992, plaintiff was approved for social security disability benefits for the period May 6, 1990 through September 1, 1991. *See* Exh. E to plaintiff's brief in response to defendant's motion. However, plaintiff had been receiving

long-term disability payments from defendant insurance company since May 1990, and the award of social security benefits created an overpayment. As a consequence, defendant withheld plaintiff's long-term disability payments until $7,000 was repaid to defendant. After negotiation, defendant agreed to reduce the overpayment amount to $3,500. *See id.*

In early 1992, plaintiff was sent by defendant-company to a neurologist, Dr. Francis P. Judge, for an independent medical examination. In a letter dated June 3, 1992, defendant sent Dr. Judge a list of questions concerning plaintiff. *See* Exh. E to plaintiff's brief in response to defendant's motion. The questions related to the doctor's diagnosis, prognosis, objective findings, as well as proposed limitations or restrictions on plaintiff's activities. *See id.* On July 13, 1992, Dr. Judge evaluated plaintiff and issued a report, concluding that plaintiff was <u>not</u> disabled and had <u>no limitations whatsoever</u>. *See* Exh. F. to plaintiff's brief in response.

In a letter dated October 29, 1992, defendant informed plaintiff that because she was not disabled from "all occupations," plaintiff was not entitled to continued coverage under the Plan. Defendant subsequently denied plaintiff's long-term disability claim. It is undisputed that defendant had paid long-term disability benefits to plaintiff for the two prior years, i.e., from November 7, 1990 until November 7, 1992. Plaintiff requested review of defendant's denial of her claim. Defendant reviewed plaintiff's file two more times, and sent two follow-up letters upholding its denial of plaintiff's long-term disability claim. *See* Exhs. B(5), B(6), and B(8) to

defendant's brief in support of motion for summary judgment.[3]

On May 4, 1998, plaintiff Willie Mae Hunter, as conservator of Regina Elizabeth Hunter, filed the instant action in Wayne County Circuit Court, State of Michigan (Case No. 98-813743-CZ).[4] Plaintiff alleged a state law claim of breach of contract, as well as denial of long-term disability benefits in violation of ERISA, 29 U.S.C. § 1132(a)(1)(B). On June 3, 1998, defendant filed its notice of removal, invoking federal jurisdiction premised on both diversity of citizenship pursuant to 28 U.S.C. § 1332 and the existence of a federal question pursuant to 28 U.S.C. § 1331. Plaintiff has not contested removal.

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[3]One requirement in an action brought pursuant to ERISA for review of denial of benefits is that plaintiff must exhaust all administrative remedies prior to initiating the action in federal court. *See* 29 U.S.C. § 1133(2); *see also* Miller v. Met. Life Ins. Co., 925 F.2d 979, 986 (6th Cir. 1991); Baxter v. C.H. Muer Corp., 941 F.2d 451 (6th Cir. 1991). As indicated above, plaintiff has met this preliminary threshold in the case at bar.

[4]As mentioned above, although plaintiff brought the instant action in the name of "Willie Mae Hunter, as conservator of Regina Elizabeth Hunter," the Court issued a stipulated order on January 22, 1999, allowing an amended case caption. That order changes the caption to read, "Raymond Cochran, as conservator of Regina Elizabeth Hunter."

II. SUMMARY JUDGMENT IS NOT AVAILABLE IN ERISA DENIAL OF BENEFITS ACTIONS.

At the outset, the Court notes that the U.S. Court of Appeals for the Sixth Circuit in Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609 (6th Cir. 1998), has held that summary judgment procedures are "inapposite to the adjudication of ERISA actions" to recover benefits. *See id.* at 619; *see also* Eriksen v. Met. Life Ins. Co., 39 F. Supp. 2d 864, 1999 WL 118318 (E.D. Mich. Feb. 23, 1999)(Rosen, J.). In Wilkins, the court held that "because this court's precedents preclude an ERISA action from being heard by the district court as a regular bench trial, it makes little sense to deal with such an action by engaging a procedure designed solely to determine 'whether there is a genuine issue for trial.'"[5] Wilkins, 150 F.3d at 619; *see also* Erikson, 1999 WL

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[5]The Sixth Circuit in Wilkins provided the following "suggested guidelines" for district courts to follow in adjudicating an ERISA action:

> 1. As to the merits of the action, the district court should conduct a de novo review [unless the "arbitrary or capricious" standard is applicable] based solely upon the administrative record, and render findings of fact and conclusions of law accordingly. The district court may consider the parties' arguments concerning the proper analysis of the evidentiary materials contained in the administrative record, but may not admit or consider any evidence not presented to the administrator.
>
> 2. The district court may consider evidence outside

118318, *1. In keeping with Wilkins and Judge Rosen's recent opinion in Erikson, this Court will evaluate the instant motion not as a motion for summary judgment but rather as motion for entry of judgment seeking affirmance of the plan administrator's decision to deny plaintiff's claim for long-term disability benefits.

III. STANDARD OF REVIEW

The United States Supreme Court has held that a denial of benefits challenged under ERISA is to be reviewed under a *de novo* standard of review, unless the plan in question gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S. Ct. 948, 956, 103 L. Ed. 2d 80 (1989). "In reviewing a plan administrator's benefits decision,

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> of the administrative record only if that evidence is offered in support of a procedural challenge to the administrator's decision, such as an alleged lack of due process afforded by the administrator or alleged bias on its part. This also means that any prehearing discovery at the district court level should be limited to such procedural challenges.
>
> 3. For the reasons set forth above, the summary judgment procedures set forth in Rule 56 are inapposite to ERISA actions and thus should not be utilized in their disposition.

Id. at 619.

a threshold question is whether the plan gives the decision-maker discretionary authority to rule on benefit claims." Equitable Life Assurance Society of the United States v. Crysler, 66 F.3d 944, 949 (8th Cir. 1995). "If it does, then the plan administrator or insurer must make the initial decision, which the court then reviews under a deferential standard of review." *Id.* (citing Donatelli v. Home Ins. Co., 992 F.2d 763, 765 & n. 2 (8th Cir. 1993)). This deferential standard has been described as an inquiry into whether the plan administrator's decision was "arbitrary and capricious," or "'rational in light of the plan's provisions.'" Perry v. United Food & Comm'l Workers District, 64 F.3d 238, 242 (6th Cir. 1995)(quoting Miller v. Metropolitan Life Ins. Co., 925 F.2d 979, 984 (6th Cir. 1991)).

It is apparent in the present case that the Plan does give discretionary authority to the plan administrator to determine eligibility for benefits. The Plan expressly requires that "satisfactory written proof" of disability be received before benefits are payable. *See* Exh. B(1) to defendant's brief in support of motion for summary judgment. As the Plan provides, "we will pay the LTD BENEFIT described in Part 8 upon satisfactory written proof that you have become DISABLED while insured under the GROUP POLICY." *Id.*, p. 6. In another section relating to claims provisions and procedures, the Plan further provides that "no LTD BENEFITS will be paid until we receive satisfactory written proof. . . ." *Id.*, p. 18.

The Sixth Circuit has held that when an ERISA-qualified plan requires plan members to provide proof of disability in order for the plan member to be entitled to benefits, the plan is "authorized to exercise discretion" in

awarding benefits. Miller v. Met. Life Ins. Co., 925 F.2d 979, 983 (6th Cir. 1991). Courts have considered the following provisions sufficient to grant discretion: "on the basis of medical evidence satisfactory to the corporation," Roberson v. Gen. Motors Corp., 801 F.2d 176, 178 (6th Cir. 1986), "on the basis of medical evidence satisfactory to the insurance company," Miller, 925 F.2d at 983, and "on the basis of medical evidence satisfactory to the Committee." Hanser v. Ralston Purina Co., 821 F. Supp. 473, 477 (E.D. Mich. 1993). As the Sixth Circuit stated on another occasion, the "critical requirement" is that "the evidence of disability be satisfactory." Yeager v. Reliance Standard Life Ins. Co., 88 F.3d 376, 381 (6th Cir. 1996).

Despite the discretion afforded to the plan administrator in determining eligibility of benefits, plaintiff maintains that certain "limitations" should be recognized in applying the arbitrary and capricious standard in cases where a conflict of interest exists. Plaintiff cites case law from various circuits holding that in applying the arbitrary and capricious standard, "a court must weigh as a relevant factor whether an insurer operates under an inherent conflict of interest, by both administering a plan and paying benefits out of its own funds." Zuckerbrod v. Phoenix Mut. Life Ins. Co., 78 F.3d 46, 49 (2d Cir. 1996); *see also* Sweatman v. Comm'l Union Ins. Co., 39 F.3d 594 (5th Cir. 1994)(applying an abuse of discretion standard); Florence Nightingale Nursing Svc. Inc. v. Blue Cross/Blue Shield of Alabama, 41 F.3d 1476 (11th Cir. 1995), *cert. denied*, 514 U.S. 1128 (1995)(holding that claims administrator not entitled to deferential standard of review, but had burden to prove that its decision was not tainted by self-interest); Bedrick v. Travelers Ins. Co., 93 F.3d 149 (4th Cir. 1996)(finding that

company which both funded and administered ERISA plan did not evaluate participant's claims in manner consistent with duty of loyalty); Bogue v. Ampex Corp., 976 F.2d 1319 (9th Cir. 1992), *cert. denied*, 507 U.S. 1031 (1993)(applying abuse of discretion standard).

It is a well-settled rule that a district court is bound by the decisions of the circuit court of appeals in which it sits. Lawrence v. Travelers' Ins. Co., 6 F. Supp. 428, 429 (E.D. Pa. 1934). This Court therefore must look to the applicable Sixth Circuit rules in applying the arbitrary and capricious standard in light of an asserted conflict of interest. In Miller v. Auto-Alliance Int'l Inc., 953 F. Supp. 172 (E.D. Mich. 1997)(Gadola, J.), this Court examined a similar argument brought by a plaintiff who claimed that a *de novo* standard should be applied due to an alleged conflict of interest. In rejecting this position, this Court in Miller looked to Sixth Circuit precedent which recognized that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor[] in determining whether there is an abuse of discretion.'" *Id.* at 176 (quoting Davis v. Kentucky Finance Cos. Retirement Plan, 887 F.2d 689, 693 (6th Cir. 1989) and Firestone, 489 U.S. at 115, 109 S. Ct. at 956-57)).

In light of the above, this Court finds that the arbitrary and capricious standard is the proper standard of review to be applied in the instant case. The existence of a conflict of interest, assuming such a conflict is found, will be weighed as one factor in determining whether defendant Trans-General's decision to deny plaintiff's long-term disability benefits was arbitrary and capricious. "'The arbitrary and capricious standard is the least demanding form of judicial review of

administrative action' and. . .' when it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious.'" Davis, 887 F.2d at 693.

IV. ANALYSIS

A. Plaintiff's state law claim of breach of contract is preempted by ERISA.

As a preliminary matter, the Court notes that plaintiff's state law breach of contract claim is subject to preemption pursuant to ERISA, 29 U.S.C. § 1144(a). In the complaint, plaintiff alleges that "[d]efendant's cut off of long term disability benefits is a breach of the disability insurance contract between Defendant and Plaintiff's former employer, Detroit East, Inc." Complaint ¶ 11. The parties are in agreement that this state law claim for breach of contract is preempted under the comprehensive statutory scheme contained within ERISA. *See* 29 U.S.C. § 1002-1003. It is well-established that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a).

B. The plan administrator's decision to terminate plaintiff's long-term disability (LTD) benefit payments was not arbitrary and capricious under the circumstances of the instant case.

In reviewing the decision of the plan administrator, a court will look only to the evidence that was before the administrator at the time the final decision was made. Holsey

MD v. UNUM Life Ins. Co., 944 F. Supp. 573, 576-577 (E.D. Mich. 1996)(Gadola, J.); *see also* Perry v. Simplicity Eng'g, 900 F.2d 963 (6th Cir. 1990). Plaintiff urges this Court to look beyond the closed record at evidence relating to plaintiff's lack of judgment and inability to manage her own affairs, as well as to other evidence of cognitive impairment. While plaintiff concedes that restricting review to the closed record is the correct general rule, plaintiff contends that "this case presents very unique facts which call for an application of an exception to the general rule." Plaintiff's brief in response, p. 14. However, plaintiff proffers no case law or other authority in support of her position that this Court may look beyond the evidence which was before the plan administrator. As a consequence, this Court finds that it is bound to consider only the evidence that was before the administrator at the time the final decision was made.

Defendant argues that under the arbitrary and capricious standard of review, "an administrator's decision will be overturned only upon a showing of internal inconsistency, bad faith, or some other ground for calling such determinations into question." Maxwell v. Twp. of Clinton, 1994 U.S. Dist. LEXIS 7862, *10 (E.D. Mich. 1994) (Gadola, J.) (citing Davis v. Kentucky Fin. Cos. Retirement Plan, 887 F.2d 689, 695 (6th Cir. 1989)). "If the administrator's evaluation or interpretation has a rational basis, a court reviewing the determination under the arbitrary and capricious standard should not disturb that determination." *Id.* (citing Miller v. Metropolitan Life Ins. Co., 925 F.2d 979, 982 (6th Cir. 1991)). Defendant also cites this Court's recent decision in Rakoczy v. Traveler's Ins. Co., 959 F. Supp. 777 (E.D. Mich. 1997) (Gadola, J.),

discussing the arbitrary and capricious standard as applied in ERISA cases:

> [u]nder this highly deferential standard of review, the outcome of the plan administrator will be upheld if "it is possible to offer a reasoned explanation, based on the evidence, for [that] particular outcome. . . ." Davis, 887 F.2d at 693 (quoting Pokratz v. Jones Dairy Farm, 771 F.2d 206, 209 (7th Cir. 1985)). The court may not substitute its judgment for the defendant's judgment, but rather "must determine whether in light of the relevant facts, [defendant] articulated a rational connection between the facts found and the choice made." Smart v. State Farm Ins. Co., 868 F.2d 929, 936 (7th Cir. 1989) (citation omitted). Indeed, a decision by the defendant will be upheld so long as the decision does not run contrary to Congressional intent, or entirely fail to consider an important aspect of the problem, or is not in accord with the plain meaning of the Policy or is so implausible that it could not be ascribed to a difference in view. *Id.* In applying this standard, the court only considers the evidence that was before the decision-maker when it made its final decision. Perry v. Simplicity Eng'g, 900 F.2d 963, 966 (6th Cir. 1990); Crews v. Central States, 788 F.2d 332, 336 (6th Cir. 1986). The court does not conduct a de novo evidentiary hearing. *Id.*

Rakoczy, 959 F. Supp. at 782 (footnotes omitted).

Defendant further maintains that the Plan clearly mandates a change in the definition of "disability" after long-term disability benefits have been paid out for a term of 24 months. As the Plan provides, "[u]ntil LTD DISABILITY BENEFITS have been paid for 24 months, you are only required to be DISABLED from your own occupation. . . . [a]fter LTD DISABILITY BENEFITS have been paid for 24 months, you must be DISABLED from all occupations." *See* Exh. B(1) to defendant's brief in support, pp. 4-5 (emphasis added). Plaintiff was notified of the change in the definition of disability in a letter dated January 2, 1992. *See* Exh. B(2) to defendant's brief in support. In that letter, defendant stated that in making its decision, it would consider "your medical condition and the restrictions it may place upon your ability to work with reasonable continuity; the skills and knowledge you gained from your education and past experience; your prior occupation(s); and whether you can perform jobs compatible with your activity capabilities." *Id.*, p. 2.

In making its decision to terminate long-term disability benefits, defendant contends that it reviewed, among other documents, the January 24, 1992 Attending Physician's form prepared by plaintiff's family doctor, Dr. John L. Loomis. In that form, Dr. Loomis indicated that plaintiff was not totally disabled from doing her job or any other work. *See* Exh. B(3) to defendant's brief in support. In addition, defendant maintains that it reviewed the July 16, 1992 report from Dr. Frank P. Judge. In that report, Dr. Judge stated that "my diagnosis is that this patient has no evidence of any neurological disease and no evidence of any closed head injury." *See* Exh. A(11) to defendant's brief in support, p. 2. The doctor added that he would "not place any limitations [or] restrictions on this patient." *Id.*

After plaintiff wrote a letter to defendant dated December 10, 1992, requesting review of the decision to terminate benefits, defendant received information from another of plaintiff's treating physicians, Dr. Mary Ann Guyon. *See* Report of Dr. Guyon, attached as Exh. B(7) to defendant's brief in support. Defendant maintains that Dr. Guyon's report indicated significant improvement in plaintiff's condition. Upon reviewing the information contained in Dr. Guyon's report, the plan administrator sent plaintiff a final denial letter, stating that "information contained in [Dr. Guyon's report] indicates you are able with reasonable continuity to perform the material duties of any occupation for which you are reasonably fitted by education, training and experience." *See* Exh. B(8) to defendants' brief in support, p. 1.

In the alternative, defendant argues that plaintiff is barred from receiving further benefits because of the very nature of her disability. Plaintiff's complaint filed May 4, 1998 states unequivocally that plaintiff is claiming disability due to "insanity." *See* Complaint ¶ 10. Defendant cites the limitations section of the policy in question, which states, in pertinent part, as follows:

> MENTAL DISORDER: Payment of LTD BENEFITS is limited to 24 months for each period of disability caused or contributed to by a MENTAL DISORDER. . .MENTAL DISORDER means a mental, emotional, or behavioral disorder."

Id., p. 6 (emphasis added). According to defendant, since plaintiff received LTD benefits for the 24-month period from

November 7, 1990 to November 7, 1992, this period exhausted plaintiff's entitlement to LTD benefits. *See* Exh. B(1) to defendant's brief in support, p. 7.

In response, plaintiff maintains that defendant relied only on Dr. Judge's July 16, 1992 report. According to plaintiff, the findings in Dr. Judge's report are not credible. First, plaintiff criticizes Dr. Judge for performing a "neurologic" evaluation, as opposed to a "neuropsychological" examination. *See* plaintiff's brief in response, p. 16. Because Dr. Judge only performed a "physical" examination, the results of which were normal, and failed to review plaintiff's MRI and EEG reports, plaintiff maintains that the doctor failed to uncover any of her cognitive and behavioral deficits. *Id.*, 16-17. Plaintiff attempts to support this assessment by citing Dr. Guyon's narrative report discussing an office visit with plaintiff on October 12, 1992. In the report, Dr. Guyon states that "physically [plaintiff] was doing fine. . . [If Dr. Judge had] assessed cognitive and behavioral deficits, he would have found residuals of her closed head injury, which were far less as time goes by than previously." *Id.*, p. 17. Plaintiff utterly fails to address defendant's alternative argument regarding the limitation on the policy in question with respect to disability caused or contributed to by a mental disorder.

Due to the foregoing considerations, the Court finds after a thorough review of the administrative record that defendant Trans-General did not act arbitrarily and capriciously in denying plaintiff Hunter's request for continued long-term disability benefits. Plaintiff has not come forward with any evidence showing that the plan administrator made its decision to deny benefits in bad faith.

See Maxwell, 1994 U.S. Dist. LEXIS 7862, *10 (Gadola, J.). Although plaintiff argues initially that an inherent conflict of interest exists because defendant both administers the Plan and pays benefits out of its own funds, plaintiff has offered no evidence to suggest that this alleged conflict played any part in defendant's decision-making process.

In addition, plaintiff's criticism that defendant based its decision solely on the opinion of Dr. Judge is not borne out by the record. Defendant has presented evidence of Attending Physician Loomis' statement dated February 4, 1992, providing that plaintiff is not totally disabled from doing her own job or any other work. *See* Exh. B(3) to defendant's brief in support. Moreover, defendant re-evaluated plaintiff's claim for benefits after the initial denial. At that point in time, defendant relied upon Dr. Guyon's report dated December 7, 1992. That report was very positive and indicated that plaintiff was exercising, applying for jobs, and continuing to do volunteering and grant writing. *See* Exh. B(7) to defendant's brief in support. Given these three sources--Dr. Loomis' statement, Dr. Judge's evaluation, and Dr. Guyon's report--defendant's determination that plaintiff was not disabled from all occupations cannot be said to have been arbitrary and capricious. Defendant has offered a reasoned explanation, based upon the evidence, for its decision to deny plaintiff's continued long-term disability benefits.

It is important to note that even if defendant had based its decision solely on Dr. Judge's evaluation, as plaintiff claims, plaintiff would still not be entitled to further long-term disability benefits. Defendant has advanced an alternative reason for the denial of benefits which plaintiff, in her

responsive brief, fails to address. It is the Court's opinion that this alternative reason, in and of itself, is sufficient to prevent plaintiff from receiving any further benefits.

As mentioned above, plaintiff states in her complaint that "[s]ince the motor vehicle accident in 1990, plaintiff has been under the disability of insanity as defined in [M.C.L. §] 600.5851." Complaint ¶ 10.[6] Thus, by her own admission, plaintiff is claiming insanity. As a result, her condition clearly falls within the limitations section contained on page 7 of the Plan. *See* Exh. B(1) to defendant's brief in support, p. 7. As discussed, that provision states, in pertinent part, that

> [p]ayment of LTD BENEFITS is limited to 24 months for each period of disability caused or contributed to by a MENTAL DISORDER. However, if you are a resident patient in a HOSPITAL at the end of the 24 months, this limitation will not apply while you remain continuously confined.

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[6]Mich. Comp. Laws § 600.5851 provides, in relevant part, that

> [t]he term insane as employed in this chapter means a condition of mental derangement such as to prevent the sufferer from comprehending rights he or she is otherwise bound to know and is not dependent on whether or not the person has been judicially declared to be insane.

M.C.L. § 600.5851(2).

> MENTAL DISORDER means a mental, emotional, or behavioral disorder.

Id. Plaintiff's claim of a "mental disorder" is further underscored by her reliance on M.C.L. § 600.5851 in her responsive brief. In that context, plaintiff argues that "this Court should take notice of the Michigan statute regarding disabilities of infancy or insanity, M.C.L. § 600.5851(1) which tolls the statute of limitations for a person under a disability of infancy or insanity. . . ." *See* plaintiff's brief in response, p. 15.

Since plaintiff is clearly claiming that her disability was caused or contributed to by a mental disorder, there can be no question that defendant's decision to deny further long-term disability benefits was "rational in light of the plan's provisions." Miller, 925 F.2d at 984. "When it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious.'" Davis, 887 F.2d at 693. Moreover, there is no indication that plaintiff falls within the exception to the mental disorder limitation, i.e., that plaintiff was "a resident patient in a HOSPITAL at the end of the 24 months. . . ." Exh. B(1) to defendant's brief in support, p. 7.

For the reasons discussed hereinabove, the Court finds that defendant Trans-General's decision to deny plaintiff's continued long-term disability benefits was not arbitrary and capricious. The Court will therefore grant defendant's motion for summary judgment, construed as a motion for entry of judgment seeking affirmance of the plan administrator's decision to deny plaintiff's claim for long-term disability benefits.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that defendant Trans-General's motion for summary judgment, construed as a motion for entry of judgment seeking affirmance of the plan administrator's decision to deny plaintiff's claim for long-term disability benefits is **GRANTED;**

IT IS HEREBY ORDERED that the hearing on defendant's motion for summary judgment previously scheduled for August 4, 1999 is **CANCELED**.

A judgment in accordance with this memorandum opinion and order shall be entered forthwith.

SO ORDERED.

Dated: 7/30/99

/s/_____
HON. PAUL V. GADOLA
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

[Filed July 30, 1999]

CIVIL CASE NO. 98-40191

RAYMOND COCHRAN, as conservator of Regina Elizabeth Hunter,
Plaintiff,

v.

TRANS-GENERAL LIFE INSURANCE COMPANY,
Defendant.

JUDGMENT

The Court, having granted defendant Trans-General Life Insurance Company's motion for summary judgment, construed as a motion for entry of judgment seeking affirmance of the plan administrator's decision to deny plaintiff's claim for long-term disability benefits, the Honorable Paul V. Gadola, presiding.

It is hereby **ORDERED** and **ADJUDGED** that the above-entitled action is dismissed on the merits;

It is herby **ORDERED** and **ADJUDGED** that judgment be entered in favor of defendant Trans-General Life Insurance Company and against plaintiff Raymond Cochran, as conservator of Regina Elizabeth Hunter.

Dated at Flint, Michigan, this 30th day of July, 1999.

APPROVED:

DAVID WEAVER

by: /s/_____
Deputy Court Clerk

/s/_____
HON. PAUL V. GADOLA
UNITED STATES DISTRICT JUDGE